MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
January 16, 2014, 9:30 am to 3:00 pm
United Way Conference Center, Room F
1111 9th Street, Des Moines, IA
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Neil Broderick
Richard Crouch
Lynn Grobe
Chris Hoffman
David Hudson (by phone)
Betty King (by phone)
Brett McLain
Rebecca Peterson
Deb Schildroth
Patrick Schmitz
Susan Koch-Seehase (by phone)
Marilyn Seemann
Suzanne Watson
Jack Willey

MHDS COMMISSION MEMBERS ABSENT:

Jill Davisson
Senator Joni Ernst
Senator Jack Hatch
Representative Dave Heaton
Representative Lisa Heddens
Sharon Lambert

OTHER ATTENDEES:

Theresa Armstrong	MHDS, Bureau Chief Community Services & Planning
Bob Bacon	U of Iowa Center for Disabilities and Development
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI
Diane Diamond	DHS, Targeted Case Management
Eric Donat (by phone)	Advocate
Jacob Dornbush	Pathways Behavioral Services
Marissa Eyanson	Easter Seals
Connie Fanselow	MHDS, Community Services & Planning
Jim Friberg	Department of Inspections and Appeals
Mark Hanson	Area Agencies on Aging; Dallas County
Melissa Havig	Magellan Health Services
Jan Heikes	MHDS, Community Services & Planning
Laura Larkin	MHDS, Community Services & Planning
Todd Lange (by phone)	Magellan Health Services
Jim Rixner	Siouxland Mental Health Center
Renee Schulte	DHS Consultant

WELCOME AND CALL TO ORDER

Jack Willey called the Commission business meeting to order at 9:35 a.m., welcomed attendees, and led introductions. No conflicts of interest were identified for today's meeting. Quorum was established, with 11 members present and two participating by

phone. Jack extended a special welcome to former Commission member Jan Heikes, who has recently joined the MHDS staff as a Community Services Consultant.

APPROVAL OF MINUTES

Richard Crouch made a motion to approve the minutes of the December 5, 2013 meeting as presented. The motion was seconded by Lynn Grobe and passed unanimously.

AUTISM SUPPORT PROGRAM RULES

Laura Larkin presented on overview of the Autism Support Program Administrative Rules. These rules were presented to the Commission for the first time on October 17, when they were approved to move on to the Administrative Rules Review Committee and be published for public notice. This program was created and added to the Iowa Code as a new chapter, 225D, by Senate File 446. The Autism Support Program provides funding for ABA (Applied Behavior Analysis) services to children under the age of nine who are not eligible for services through Medicaid or private health insurers and whose income is below 400% of FPL (Federal Poverty Level). Many private insurance carriers do not fund ABA services; the State Employees Health Insurance Program does.

The rules follow specific guidelines in the law in identifying financial and diagnostic eligibility standards, application and authorization processes, provider network qualifications, and the appeal process. The legislation limits services to ABA and care coordination. It also called for an expert panel of stakeholders to be convened, which assisted the Department in developing the proposed rules. The panel included parents of children with autism, providers of services, and other stakeholders.

The only comments received during the public comment period were submitted by the members of the Autism Expert Panel. Laura reviewed each of the ten comments and responses:

1. Eligibility and application requirements – This comment stated that the rules should include language clarifying who can provide diagnostic assessments and whether providers that make a diagnostic assessment can then also provide treatment services. DHS responded that the rules include a definition of a "diagnostic assessment of autism" and there is nothing in the law or in rules that prohibits a person from providing both a diagnosis and ABA under the program. No changes were made.

2. Integrated health homes – This comment stated that the term "integrated health home" (IHH) needs more clarity and suggested changing it to "pediatric integrated health home." DHS responded that the term IHH is consistent with the Iowa Code and that pediatric integrated health home is not defined in Iowa Code or Iowa Administrative Code. No changes were made.

3. Development of new integrated health homes – This comment asked if the Legislature intended that families could also be served by other types of integrated health homes if they are developed. DHS responded that the Legislature did not make any intent known regarding future utilization of different types of integrated health homes. These rules are written to address the use of integrated health homes for children with SED, which are currently available in Iowa. No changes were made.

4. Service authorization – This comment stated that clarity is needed regarding acceptable methodology/tools to be used to obtain baseline and other standardized assessment scores and how the tools would be chosen. DHS responded that the administrator of the Autism Support Program will be selected through a request for proposal process and will be responsible for selecting the standardized assessment tool, which must be approved by DHS prior to implementation. No changes were made.

5. Provider network – This comment stated that there is an extreme shortage of Board Certified Behavior Analysts (BCBAs) in Iowa and more language is needed to give latitude to providers allow licensed health professionals working under the supervision of BCBAs to deliver services. DHS responded that the rules allow treatment plans to include services proved by non-BCBA staff under the supervision of BCBAs. This is consistent with the national model of ABA service delivery. No changes were made.

6. Provider eligibility – This comment states that clarity is needed regarding provider eligibility. DHS responded that the rule did not require providers to be Medicaid certified, but deemed those Medicaid certified as eligible. The language was changed for clarity.

7. Provider eligibility – This comment states that specificity is needed to determine which health professionals licensed under Iowa Code Chapter 147 are appropriately trained to serve children and youth with autism spectrum disorders. DHS responded that the proposed rules include a requirement for a health professional licensed under Chapter 147 to provide evidence of training in ABA and meet the criteria of a mental health professional under Iowa Code Sec. 228.1. No changes were made.

8. Rates – This comment concerned rates to be paid for ABA services by the Autism Support Program and stated that clarity is needed because Medicaid currently pays different rates for ABA services deliver through a variety of programs. DHS responded that that only rates established for the reimbursement of ABA services are those through the managed care behavioral health program. No changes were made.

9. Authorization of services – This comment stated that the administrator of the program should be required to utilize staff who exhibit knowledge of ASD (Autism

Spectrum Disorders) and ABA to make sound decisions regarding authorization of services. DHS responded that the administrator selected would be expected to provide sufficiently trained and experienced staff to administer all aspects of the program. No changes were made.

10. Use of telehealth – This comment stated that telehealth is mentioned in the Senate File 446 legislation, but not in the rules and that it should be recognized as an acceptable method of service delivery. DHS responded that there is nothing in Code or in rules that restricts the use of telehealth in this program, as long as it meets service standards and is used appropriately. No changes were made.

The Department released the RFP (Request for Proposals) in November and received only one response by the closing date. Magellan Health Services was the successful bidder and has been selected as the administrator for the program. A contract is being developed and the Department hopes to have it in place before April 1. Theresa Armstrong said that since Magellan already pays for ABA services through the Iowa Plan, the implementation is expected to go smoothly. Once approved, the rules will take effect April 1.

Motion – Neil Broderick made a motion to approve the rules as presented, pending the approval of the Administrative Rules Review Committee. Patrick Schmitz seconded the motion. The motion passed unanimously.

MHDS/DHS UPDATE

Theresa Armstrong presented an update on MHDS and Department activities.

Governor's Budget – The Governor's budget was released on Tuesday. It includes $29.8 million for equalization. It is still being reviewed and more details will be available soon. An appropriations bill will be coming out later in the legislative session.

Regional Development – Department leadership had an in-person meeting with leadership from all of the regions yesterday. Rick and Theresa participated from MHDS, Jennifer Vermeer and Debbie Johnson, the Bureau Chief for Long Term Care and Services from IME (Iowa Medicaid Enterprise), and Maria Montanaro and Kelly Pennington from Magellan gave updates. Jennifer talked about the Iowa Health and Wellness Plan. They had good discussions about how they envision systems starting to look and how to work together to keep moving in the same direction. Suzanne Watson said it was a good meeting, although there was not enough time to get through the full agenda. They agreed to hold face-to-face meetings every other month and phone meetings every other month.

28E Agreements – DHS has received eight 28E agreements so far. MHDS worked with ISAC (Iowa State Association of Counties) to develop a template for the agreements, and most regions are following that closely. They are being reviewed carefully to make

sure all the Code requirements have been included and followed before the Department provides feedback to the regions. Theresa noted that there would be some things in the agreements that will have to be corrected or added to comply with Code provisions and other changes or additions that the Department may suggest as improvements, but that would not preclude approval. For example, language is recommended to make it clear that if an individual county is delinquent and becomes a non-voting member of the governing board, the individuals in that county will be held harmless. Another example would be language that clearly identifies that regional staff report to the administrative entity.

Examples of Code requirements that have to be included are: Clearly identifying a method for acquiring real property, and clearly identifying a method for pooling or managing money, and it must be clear that managing funds falls under the responsibility of the governing board. If those items were not included in an agreement, they would have to be added before it could be approved. Rick Shults has said that the Department will try to have approvals out in the next couple of weeks.

Equalization Payments:

- 54 counties were eligible for $29.8 million in equalization payments
- 41 counties have received full payments
- 6 counties asked for their full payment to go to paying their State bills
- 3 counties paid their State bills and received additional funds
- 2 counties received partial payments with the rest of the funds held for outstanding bills
- 2 counties have not yet received any equalization payment

In response to a question, Theresa clarified that this $29.8 million was for “equalizing” property taxes among counties so that they all have $47.28 per person available to spend on MHDS services. If the equalization funding is to continue, the legislature will have to authorize it for future years.

County Funding Issues – Theresa shared a spreadsheet showing eleven counties that self-identified as having possible funding issues for FY2014 in response to a request from ISAC. Julie Jetter has started working with them. The spreadsheet shows available funds from the county levy, equalization funds, SSBG/SPP (Social Service Block Grant/State Payment Program), and any other sources. Starting with the beginning cash fund balance for each county, and adding FY14 funding sources, subtracting estimated expenditures, any remaining state bills, the sheet shows a projected ending fund balance and any remaining amount of potential need. It also shows the amount needed for each county to have a 25% carry forward to get them through the first quarter of the fiscal year until fall property tax revenues are collected.

After reviewing the information, it was determined that five of the counties had no need. The other six counties have a potential combined need without any carryover of $317,347, and a potential need of about $1,078,440 when a 25% carry-forward is

included. The next step is completing a similar process for all counties and looking at the need region by region as well.

David Hudson said he thought the need was far greater than that just a few months ago. Theresa responded that many counties thought it was, but some things have become clearer and some things have changed since those predictions.

Theresa noted that this analysis does not take into account any impact from the Iowa Health and Wellness Plan. Suzanne Watson said that some counties had more money budgeted for Medicaid billings than they needed because at the time their budgets were certified they did not know when county Medicaid billings would stop. She also noted that the change to residency has shifted cost responsibility for vocational and other services between counties and the result is that some have more costs than expected, while others had money budgeted they no longer need to use. Deb Schildroth said that it also depends on where counties are in the regional process. She noted that her region has pooled funds and established a safety net fund that will be available for any county that experiences a cash flow crisis.

Theresa noted that it was a very difficult year for counties to accurately predict their funding needs and that there was fear that there would be many county waiting lists for non-Medicaid services, but currently there are only three counties with waiting lists and it is anticipated that those lists will be eliminated once the regions are fully formed.

Hospital Bed Tracking Report – The Inpatient Hospital Bed Tracking Report was submitted to the legislature on December 15. The Department was charged with making recommendations for developing an electronic system to track the availability of inpatient hospital beds throughout the state and provide real time central reporting. A group of magistrates approached the Director and offered to work on the issue. The Department also engaged the Iowa Hospital Association in the discussions. Their final recommendations were that such a system should be established, with the recognition that the system would not solve all the problems with access to beds. For example, hospitals still have rules such as establishing that people are medically stable before they are transported. There are also federal rules related to when beds can be held. Even with such a system, there will be a need to get additional information on individuals before they are matched with a bed, but the system should greatly reduce the number of calls that need to be made from 20 to 30 down to five or six. The group did recommend that the system includes some specific data such as gender, behavioral characteristics, and need for a private or shared room.

IDPH currently has an emergency system called the Center for Disaster Operations and Response that is the same concept but it is intended to be put into place only in emergency situations. It is not kept up to date because there is no requirement to do so. The recommendations included either building on that system or creating a stand-alone system. Either one would have to be updated and maintained on a regular basis. Hospitals would be responsible for keeping the information updated for the system to be successful.

Cost estimates varied. To upgrade the existing system would require a one-time investment of about $50,000; to set up a new system would require a one-time investment of about $200,000. Annual costs for operating the IDPH system would be about $120,000, and annual costs for operating a new system for this limited purpose would be about $25,000.

Crisis Stabilization Pilot Project Report – The report on the crisis stabilization project in the CSS Region has been filed. Renee Schulte will talk more about that later today.

IDPH MHDS Workforce Workgroup Report – Theresa noted that the report focused on licensed professionals, although unlicensed workers will also need to be addressed. Teresa Bomhoff, who participated on the workgroup, said they recommended more mental health and disability training for primary care doctors and reimbursing all providers for staff training. She said she would have liked to see more detail in the report. Bob Bacon said the report did not address direct support professionals who work in the HCBS services arena and that is an area that still needs attention.

Todd Lange commented that he is frustrated that the role of peer support and family peer support was not reflected, especially since peer support is identified as a core service. He said he hopes they will take a comprehensive look at the system and provide flexibility for regions.

Integrated Health Homes – Theresa shared a list of providers for Phase 2, which begins April 1st in 27 counties (Benton, Black Hawk, Buchanan, Calhoun, Cedar, Cerro Gordo, Clinton, Delaware, Floyd, Grundy, Hancock, Harrison, Humboldt, Iowa, Jackson, Johnson, Jones, Kossuth, Mills, Mitchell, Muscatine, Pocahontas, Pottawattamie, Scott, Webster, Winnebago, Worth, and Wright). Some lessons have been learned from Phase 1. The Phase 1 providers hired staff in anticipation of serving the whole attribution list and found they could only locate and enroll a part of them. This time, the recommendation is that they hire for about 40% of the list and build staff capacity as they are able to increase enrollment.

Melissa Havig commented that outreach for getting people enrolled prior to the start date and the training component will be areas of focus as providers get started. Theresa noted that DHS has been meeting with IHH providers every week to make sure we all know where things are at in the process of transitioning. The providers are engaged in a lot of learning and case management providers have been helping them to understand the CMH (Children's Mental Health) Waiver. The attribution lists (of potential enrollees) are expected to go out early in February so the providers will have some time to process and work on outreach.

Jim Rixner spoke about his experience as a Phase 1 provider. He said his mental health center started with a list of 1200 potential IHH enrollees; they were able to locate about 800, enroll about 400, and received payment for 231 in December. He said that they hired staff to serve about 800, and that level of staffing is obviously not sustainable with the current numbers.

Theresa Armstrong noted that people can move frequently and the addresses DHS had on record were not always current. She said Magellan has hired some additional staff to work on updating addresses. Deb Schildroth suggested that county case managers might have more current address information. Neil Broderick commented that Orchard Place, as a Phase 1 children's provider, as experienced that same problems. He said that Magellan has been good to work with and the peer support piece has been very good.

Phase 3 starts July 1st. Magellan has announced applications for provider enrollment and has some informational meetings for providers scheduled:

- January 29 in Fayette
- January 31 in Spencer
- February 3 in Ottumwa
- February 5 in Carroll
- February 7 in Creston

Iowa Health and Wellness Plan (IHAWP) – Theresa shared a handout, "Iowa Health and Wellness Plan Waiver Approval: Frequently Asked Questions." Coverage under IHAWP began January 1, as planned. Some of the waivers requested from the federal government were approved, while others were withdrawn.

- Non-emergency medical transportation will not be covered during the first year.
- There will be a co-payment for non-emergency use of emergency rooms.
- EPSDT (Early Periodic Screening, Diagnosis, and Treatment) will be covered for plan members through age 20.
- Retroactive eligibility remains a negotiating point, but will continue because it is consistent with existing Medicaid guidelines
    - Coverage will be effective on the first day of the month of application
    - Up to three months of retroactive eligibility may be available, but cannot be made retroactive to January 1.

Discussion – Rebecca Peterson said that originally residential substance abuse treatment services were to be covered, and now they are not covered. She asked why that had changed. Chris Hoffman said the Iowa Behavioral Health Association met with Jennifer Vermeer to work out the definition. He said he had understood that it would be covered for people in the Iowa Health and Wellness Plan and now it seems to only be available to people who are found to be medically exempt.

Theresa Armstrong clarified that a person cannot apply for or be determined medically exempt until they are enrolled in a plan, and then the medically exempt status does not take effect until the beginning of the month following the ME determination. February 1 would be the earliest date a person could be covered as medically exempt if that person had been accepted onto the plan and completed the application for medical exemption in January. Chris Hoffman said this medical exemption eligibility issue is affecting people who were covered by the IowaCare program. They now have to wait to be determined medically exempt to have the Medicaid coverage and that takes at least a couple of weeks. He said that right now costs for their treatment are being covered by

Block Grant funds, but he is concerned about losing 202 treatment beds in the State if the situation does not change.

Patrick Schmitz commented that the rates paid by Coventry are extremely low, and considerably less than Medicaid rates. He said that his mental health center would be receiving on average 65% less than they did from counties for the same services, and a significant portion of that is the client's responsibility. He said he is concerned that clients now have co-pays for services, and in many cases they are also paying a premium and have to meet a deductible and they do not have the resources to meet all those out of pocket costs. Suzanne Watson said she is seeing the same issue for people where are currently on Medicare and cannot meet the deductibles. Patrick added that there are items that Coventry pays nothing to the provider and the client is billed for the entire amount. He said people know have access to insurance plans, but they cannot use them to access services if that is not affordable. Chris Hoffman commented that the rates are so low providers are considering whether they should accept Coventry insurance.

Jim Rixner commented that there are also credentialing issues; he said staff have to be re-credentialed over and over for insurance purposes and he is looking at needing a full time staff person just for handling the credentialing. He said that without some of the better paying insurance companies choosing to be part of the IHAWP program, the viability community mental health centers or other providers is at risk. Patrick said that county funds have helped support CMHCs as safety net providers, and if that source is not available, private practitioners will be able to choose which clients they want to serve and who they do not.

Suzanne Watson commented that it may be important to educate state policymakers on this issue because they may believe that counties no longer will need to fund people who are covered by IHAWP and the insurance coverage doesn't seem to be meeting their needs. Chris Hoffman said the Iowa Behavioral Health Association has a meet set up with the Insurance Commissioner to discuss these kinds of issues. He noted that there was an assumption that these plans would at least match Medicaid rates and yet they are not coming close to that. Chris suggested inviting the Iowa Insurance Commissioner or someone from the Insurance Commissioner's office to a meeting.

Jack Willey asked for input on how to get the Commission's message to the Governor and legislators. Teresa Bomhoff suggested contacting the chairs of the House and Senate Human Resources Committees and the Health and Human Services Appropriations Subcommittee. Jim Rixner suggested contacting legislators who have been part of the Fiscal Viability Committee, as they are already knowledgeable about MHDS issues. Eric Donat suggested that consumers should share their stories with legislators. Theresa Armstrong noted that Jen Harbison is working with the Governor's Office to find an opportunity for representatives from the Commission to have a meeting.

Renee Schulte said that details on the Governor's budget will be available next week and will help answer questions about the $30 million for equalization and the "claw back" issue. She suggested focusing on providing information to legislators who are involved in MHDS policy and appropriations because they may not be aware of some of the gaps and challenges that are being identified as the new programs are rolled out. Bob Bacon suggested that these are not just Iowa issues; they may be national issues. He noted that Iowa has received a lot of attention for our unique bipartisan approach to Medicaid expansion so we will get more attention if we cannot implement it successfully.

David Hudson said that from his perspective as a former aide in the Governor's Office, he would recommend that if the Commission wants the Governor to hear their concerns, they should try to meet directly with him or the Lt. Governor. He said that because the Commission is a statewide Governor-appointed body that represents a broad array of interests, it would be consistent with their advisory role.

Jack Willey said that if the Commission feels it is necessary to communicate these concerns to legislators and the Governor's Office, the a workgroup will need to commit the necessary time to make sure the message can be communicated clearly and factually. Jack asked for volunteers to work on crafting a message.

Committee – Eight Commission members volunteered to serve on the Communication Committee: Chris Hoffman, David Hudson, Betty King, Rebecca Peterson, Deb Schildroth, Patrick Schmitz, Susan Koch-Seehase, and Jack Willey.

Jack will work with Connie Fanselow to set up a time for the group to meet by telephone conference.

Crisis Stabilization Services Rules – Renee Schulte presented an introduction to the development of administrative rules for crisis stabilization services. There is currently an adult crisis stabilization pilot in the County Social Services (CSS) region, which is primarily facility based. The Department wants to develop one set of administrative rules that allow flexibility for both facility-based and community-based services, and allow for regional variation.

The rules for emergency service providers are contained in Chapter 24 of the Iowa Administrative Code, but there are currently no rules in place for crisis stabilization services. DHS and DIA (Department of Inspections and Appeals) have determined that these rules should also be a part of Chapter 24, so their development will go through DHS. Other rules for subacute care services, both community and facility based, will be developed by DIA. Chapter 24 will be completely revised, with the crisis stabilization rules being the first piece. DHS will be working with the Commission as each new section of the chapter is being developed.

This started with Senate File 2315, the large mental health reform bill, in 2012. Sec. 59 of the bill called for State agency activities concerning substance abuse, crisis stabilization, and residential care facility services. DHS was to work with IDPH, DIA,

and stakeholders to create appropriate definitions and rules. The legislation said that it is the intent of the General Assembly is that the state Medicaid plan will cover both facility and non-facility subacute services and crisis stabilization services.

A 10-bed pilot project has been operating in the Waterloo area for the last 2 years; it is set to end on June 30, 2014. The legislature has received two reports on that project, The Adult Crisis Stabilization Center Pilot Project Report 2012, and The Adult Crisis Stabilization Center Pilot Project Report 2013.

The project served 163 individuals in 2012 and 277 individuals in 2013. The people served were experiencing relationship crises, substance use crises, and mental health crises. The project has partnered with Pathways Behavioral Services to perform clinical intakes for people who do not come through hospital referrals. They also provide medication management services. Chris Hoffman commented that Pathways is able to make a simple mental health assessment, diagnostic impression, substance use history, and action plan available 24/7, and can determine if there are any acute issues that would indicated that hospitalization more appropriate. Pathways uses telehealth equipment and contracts with ARNPs (Advanced Registered Nurse Practitioners) to see the folks who are coming in and make sure that psychiatric medications are appropriate and accounted for and make sure any other mental health issues are addressed.

Renee said that generally the length of stay is short term, 3 to 5 days; one person has stayed for a period of months due to a transition issue. Work needs to be done on a transitional component, but that is outside the scope of these rules. This project is adults; crisis stabilization services for children may be added later. It was noted that the approach would be to develop rules that will be easily adaptable for children's services when the time comes.

Services are to be community-based and short term. DHS started developing emergency mental health crisis services rules in 2008; those rules did not move forward but the work is still available as a resource in developing new rules now. Some of the things these rules need to address include:

- Evidence Based Practices, including trauma informed care, co-occurring services, and person-centered services
- Olmstead Principles, including choice for individuals, will be the guiding principles for the rules
- A flexible definition of crisis stabilization
- Intake and data collection
- Discharge planning
- Individualized planning standards
- Team involvement
- Staffing levels and training needed
- Programming requirements during the stay

Information has been gathered from other states, including:

- Maine, which utilizes a team approach using trained screeners and a standardized tool
- New Jersey, which has a network of services
- Nebraska, which has a strong set of rules with good definitions and uses a regional services structure similar to Iowa's
- Ohio, which has clear definitions and utilizes elements of crisis intervention
- Texas, which incorporates a huge network of services
- Tennessee, which has an entire code chapter of minimum requirements
- Arizona, which has some very good definitions for appropriate level of care
- Pennsylvania, which has standards to promote client recovery and resiliency and for medication management

Patrick Schmitz suggested looking at the Acute Care Task Force Report from several years ago. Renee said there would probably not be a draft document for the Commission to review until the March meeting, so to prepare for that, MHDS would like to have a conversation with committee members by the February meeting. She will gather materials to share with the committee members.

Crisis Stabilization Services Rules Committee – Seven Commission members volunteered to serve on the Crisis Stabilization Services Rules Committee: Neil Broderick, Chris Hoffman, Rebecca Peterson, Patrick Schmitz, Susan Koch-Seehase, Suzanne Watson, and Jack Willey. They will plan to meet with Renee in Des Moines on February 19, just prior to the next Commission meeting to review the initial draft.

Theresa Armstrong noted that there would need to be a change in Iowa Code language for licensing and accreditation of crisis services to fall with DHS and there will be a bill introduced to say that crisis stabilization services do not have to meet the specific DIA standards under Chapter 135 and others and will instead fall under DHS responsibility.

A break for lunch was taken at 12:05 p.m.

The meeting resumed at 1:15 p.m.

MHDS/DHS UPDATE (continued)

Core Standardized Assessments – IME (Iowa Medicaid Enterprise) has re-released a Request for Proposals for SIS (Supports Intensity Scale) Assessments. This is associated with the BIPP (Balancing Incentives Payment Program) to balance community-based and facility-based services and with legislation passed last year, which directed the use of core standardized assessments for persons with intellectual disabilities.

Theresa shared two handouts – the RFP announcement and Frequently Asked Questions. The RFP is for an independent contractor to perform the core standardized assessments. Currently assessments are done by Targeted Case Management staff or

staff in state institutions. The vendor will also be asked to assist in identifying future assessments to be used for persons with brain injury, developmental disabilities, or mental health conditions. Resource allocation was included in the original RFP, but not in this one; there will be separate procurement process for that function.

Federal HCBS Services Rules – CMS (Center for Medicare and Medicaid Services) released new federal rules on home and community-based (HCBS) services on January 10. Theresa shared two handouts, a "Fact Sheet" on Home and Community Based Services, and a "Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services Settings Final Rule." These rules attempt to define where HCBS services can be delivered.

The "settings provision" requires that all home and community-based settings are integrated and meet certain qualifications, including:

- The setting is integrated in and supports full access to the greater community
- The setting is selected by the individual from among options
- The setting ensures individual rights of privacy, dignity, and respect, and freedom from coercion and restraint
- The setting optimizes autonomy and independence in making life choices
- The setting facilitates choice regarding services and who provides them

There are also additional requirements for provider-owned or controlled HCBS residential settings, including:

- The individual has a lease or other legally enforceable agreement that provides similar protections
- The individual has privacy, including lockable doors, choice of roommates, and freedom to furnish or decorate the living unit
- The individual controls his or her own schedule, including having access to food at any time
- The individual can have visitors at any time
- The setting is physically accessible

Providers are still allowed to own homes where services are provided, but there has to be a lease arrangement separate from the services.

The rules lay out a person-centered planning process, and stress that individuals have the opportunity to guide their own service planning, and have choice of providers. Theresa said that if anyone has questions or feedback or knows providers who may be directly impacted by these changes to contact MHDS. She said CMS is allowing a transition period that may be up to five years, but they will expect movement to happen sooner if reasonable. The state has about a year to complete an evaluation, and then will have additional time to make transitions as needed.

Susan Koch-Seehase commented that these rules as much as expected. She said CMS would need to provide some clarification regarding eviction. She said she also thinks expectations for person-centered planning will be a challenge in some areas of

the state. Theresa noted that these rules apply to HCBS services in all settings, not just residential services, so employment and other Medicaid-funded HCBS services will be affected. These rules reflect compliance with the ADA (Americans with Disabilities Act) and the Olmstead Supreme Court Decision.

COMMISSION DUTIES DISCUSSION

Jack Willey opened the discussion of Commission duties by saying he was very pleased with the Commission's annual report, which he called a good summary of a very busy year. He asked Connie Fanselow to explain the Commission duties and timelines shown on the planning document. Connie noted that the majority of the Commission's duties are triggered by events outside of their control such as the review of reports, the development of rules by DHS, or other changes in policy or practice that are brought to the Commission for review and approval.

Connie said she has worked with Jack to make a short list of the affirmative duties the Commission needs to plan and meet timelines for completion. They are:

- Reporting annually to the Governor and the General Assembly on the activities of the Commission and making recommendations for changes in state law.
- Reporting biennially to the Governor and the General Assembly on the extent to which services to persons with disabilities are actually available in each county and the quality of those services.
- Reporting biennially to the Governor and the General Assembly on the effectiveness of the services provided by disability service providers in the state, by the state mental health institutes, and by the state resource centers.
- Advising MHDS, the Council on Human Services, the Governor and the General Assembly on budgets and appropriations concerning disability services.
- Coordinating with the Iowa Developmental Disabilities Council and the Iowa Mental Health Planning and Advisory Council

Commission members recommended a timeline to complete activities by their due dates and volunteered to serve on committees to focus on completing the tasks necessary to fulfill each of the duties.

Legislative Priorities Committee: Jill Davisson, Lynn Grobe, David Hudson, Marilyn Seemann

County/Regional Services Committee: Richard Crouch, Rebecca Peterson, Deb Schildroth, Patrick Schmitz

MHI and SRC Committee: Neil Broderick, Brett McLain, Marilyn Seemann, Suzanne Watson

Cost Increase & Communications Committee: Chris Hoffman, David Hudson, Betty King, Rebecca Peterson, Deb Schildroth, Patrick Schmitz, Susan Seehase, Jack Willey

NEXT MEETING

The next meeting of the MHDS Commission will be on February 20; the location will be announced soon. The committee working on the development of crisis stabilization rules will meet on February 19 in Des Moines.

PUBLIC COMMENT

Mark Hansen shared two handouts on the Area Agencies on Aging, including a map of the six current AAAs and their contact information. He noted that the BIPP program applies to long-term care in nursing homes for people who have disabilities because of aging and that aging network services providers are important to the effort. He said that there is a Commission on Aging in Iowa and he would like to see the MHDS Commission meet with them at some point in time. The Iowa Department on Aging is working with DHS to set up the Aging and Disability Resource Centers (ADRCs). He said the AAAs have been involved in care transition work for years, but it has always been with aging adults and they would like to become more involved with the efforts related to disability services. Services in the community are very important to the aging world. He said they manage almost 10,000 clients on the HCBS Elderly Waiver with services costing $550 to $600 a month, while a month in a nursing home costs about $5000. He encouraged contact the Iowa Association of Area Agencies on Aging to learn more about where services are and are not available in the aging network because they have been gathering that information for years.

Bob Bacon shared that IME and the MFP (Money Follows the Person) program have just heard from CMS that they have approved the revision to Iowa's operational protocol and MFP will now be able to serve individuals with intellectual disabilities living in nursing homes as well as those living in ICF/IDs (Intermediate Care Facilities for Persons with Intellectual Disabilities).

Melissa Havig said that Frequently Asked Questions about the Iowa Health and Wellness Plan are available online. People can check the Iowa Medicaid or the Magellan websites, and can also call the IME member or provider services lines with questions.

Jim Friberg said that DIA is working on the subacute services rules discussed earlier and will be meeting again soon to review a preliminary rough draft.

The meeting was adjourned at 2:15 p.m.

Minutes respectfully submitted by Connie B. Fanselow.